

Retrospective case series: The use of foam and superabsorbent dressings in wound management

CASE STUDIES SERIES 2026



Published by

Wounds International
A division of OmniaMed Communications Ltd
108 Cannon Street
London EC4N 6EU, UK
Tel: +44 (0)20 3735 8244

Email: info@omniamed.com
www.woundsinternational.com

WOUNDS | **INTERNATIONAL**

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Suggested citation

Wounds International (2026) *Retrospective case series: The use of foam and superabsorbent dressings in wound management*. Wounds International, London, UK

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Supported by an educational grant from Convatec Inc. The views expressed in this publication are those of the authors and do not necessarily reflect those of Convatec Inc.

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The authors' names are listed in the order corresponding to the sequence of the case studies presented.

Introduction

Effective wound management relies heavily on selecting dressings that not only fit the wound's specific needs but also support the patient's comfort and healing process. This case series explores the use of advanced foam dressings, with particular focus on the Aquacel® range of foam dressings, to efficiently manage wound exudate while protecting surrounding skin and promoting optimal healing in both acute and hard-to-heal wounds.

Understanding wound exudate

Wound exudate is a fluid produced during the inflammatory and proliferative phases of wound healing. Although primarily water-based, it also contains electrolytes, nutrients, cytokines, proteolytic enzymes, growth factors, waste products and immune cells (Seijo-Rabina et al, 2024).

While a moist wound environment is essential for healing, imbalances can delay the healing progress. Too much exudate can cause maceration and infection, whereas too little can delay healing.

Foam dressings play a key role in controlling exudate by absorbing excess fluid while preserving the moist environment needed for tissue repair (Hargis et al, 2024). Sieracki et al (2020) shows foam dressings also significantly support pressure injury prevention and reduce tissue deformation and stress compared to no dressing.

Aquacel® Foam dressings in exudate management

Aquacel® Foam dressings are multi-layered primary and secondary foams designed for a wide range of acute and hard-to-heal exuding wounds. They combine absorbent foam layers with Hydrofiber® technology, which absorbs exudate, swells to conform to the wound bed and reduces space for bacterial growth. When used as part of a structured care protocol, they provide (Aquacel® Foam, IFU; Waring and Parsons, 2001):

- **Moisture management:** Absorb excess exudate while preserving the moist environment needed for tissue repair. The dressing locks in fluid, reducing maceration risk. Vertical wicking prevents lateral spread of exudate, while micro-contouring minimises dead space that could encourage bacterial growth
- **Skin protection:** The waterproof, breathable film protects against external contaminants and reduces friction and shear forces. This barrier also allows moisture evaporation and enables showering or bathing
- **Comfort and gentle adhesion:** Silicone adhesives adhere lightly to the skin (not the wound), minimising trauma during dressing changes and reducing irritation.

*Refer to indications and instructions on product label approved in your local market. Requirements may vary by region.

Other Aquacel® variations include:

- **Aquacel® Foam Pro:** Combines silicone foam with Hydrofiber® for up to seven days wear time and secure, gentle application and removal with minimal trauma to surrounding skin
- **Aquacel® Extra™:** A soft, sterile, non-woven pad reinforced with regenerated cellulose fibre that transforms exudate into a soft gel, maintaining a moist environment that supports healing and aids autolytic debridement without damaging newly formed tissue. Suitable for leg ulcers, pressure ulcers (stages II-IV), diabetic ulcers, surgical wounds, burns* and oncology-related wounds.

ConvaMax™ Superabsorber in exudate management

ConvaMax™ Superabsorber adhesive and non-adhesive dressings are sterile, multilayer dressings for highly exuding wounds. Both use a Superabsorber core that absorbs and retains exudate and matrix metalloproteinases (MMPs), supporting moist wound healing and reducing maceration. The adhesive version includes a gentle silicone contact layer for secure placement, while the non-adhesive version offers flexible use under secondary fixation for diverse wound types. (ConvaMax™ Superabsorber adhesive, IFU; ConvaMax™ Superabsorber non-adhesive, IFU).

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CASE 1: Management of a chronic diabetic foot ulcer

Author details: **Jianfang Che**, Enterostomal Therapy Nurse, Endocrinology Department, Air Force General Hospital of Eastern Command, Mainland China

Clinical presentation

- A 70-year-old female presented with an infected ulcer on the right big toe and metatarsophalangeal joint [Figure 1] of 5 months duration
- **Medical history:** Type 2 diabetes, hyperlipidaemia.

Wound presentation

- **Ulcer size:** 5cm (L) x 3cm (W) x 1cm (D)
- **Tissue composition:** Moist gangrene in the interdigital space; 85% yellow slough, 15% red granulation tissue with purulent discharge
- **Wound edge:** Pigmented, excoriated and dry
- **Infection:** Significant local infection with odour.

Treatment objectives: To remove necrotic tissue and control infection.

Clinical outcomes

The wound was sharply debrided and cleansed with saline. Alginate dressings were used in the initial phase. However, after 62 days, with no significant improvement, the patient underwent surgical amputation of the right big toe [see Figure 2a].

From day 81 onwards, postoperatively, the wound was managed using Aquacel® Ag+ and Aquacel® Foam Pro, with dressing changes scheduled every 2-5 days depending on exudate levels.

Follow-up:

- **Day 113** (day 32 with Aquacel®; Figure 2b)
- **Day 121** (day 40 with Aquacel®; Figure 3a) showed significant progress, including healthy granulation tissue and reduced wound size.

By day 191 (day 101 with Aquacel®; Figure 3b), continued epithelialisation and wound contraction were observed.

Conclusion

This case involved a chronic diabetic foot ulcer managed through conservative and interventional strategies. Following limited response to alginate dressings and surgical amputation, Aquacel® Foam Pro and Aquacel® Ag+ were introduced. These dressings effectively managed exudate, reduced debridement frequency and supported granulation and epithelialisation.



Figure 1. Wound on day 1 (a) infected right big toe; (b) metatarsophalangeal joint involvement.



Figure 2. Wound on (a) day 62: post-amputation and bone cement application following non-responsiveness to conservative management with alginate dressings; (b) day 113 (32 days post-initiation of Aquacel®): granulation tissue visible, reduced wound size.

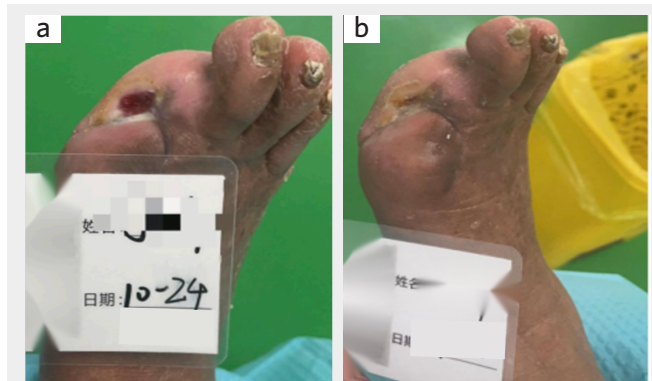


Figure 3. Wound on (a) day 121 (40 days post-initiation of Aquacel®): continued wound contraction and healthy granulation tissue formation and (b) day 191 (101 days post-initiation of Aquacel®): near-complete epithelialisation and significant reduction in wound size.

Dressing changes were gradually extended as exudate levels declined.

CASE 2: Management of a recalcitrant abscess complicated with MSSA bacteraemia

Author details: **Kavitha D/O Sanmugam**, Senior Wound Clinician/Advanced Practice Nurse, St Luke's Community Hospital, Singapore

Clinical presentation

- A 71-year-old male presented with an abscess on the upper back, complicated by methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia. Despite previous treatments, including negative pressure wound therapy, silver dressings with absorbent pads and intravenous antibiotics, the wound had failed to heal [Figure 1]
- **Medical history:** Diabetes, hypertension, hypertensive heart disease, chronic kidney disease, stroke and gout.

Wound presentation

- **Wound size:** 5.6cm (L) x 3.9cm (W) x 0.5cm (D)
- **Tissue composition:** 85% granulation tissue, 15% slough; moderate levels of exudate
- **Wound edges:** Rolled with erythema and oedema
- **Additional:** Localised warmth and clinical signs of infection; biofilm suspected with low-grade inflammation.

Treatment objectives: To reduce bacterial burden, remove slough from wound bed and decrease wound size.

Clinical outcomes

On day 1, following cleansing with an antiseptic solution, a treatment plan was initiated that included a 10-week course of blue light therapy in combination with haemoglobin spray and ConvaMax™ Superabsorber Dressings [12.5cm x 12.5cm]. Although classified as moderately exudative, the dressing required changing every other day due to saturation.

By day 18, the wound measured 5.7cm (L) x 3.6cm (W) x 0.5cm (D). Granulation tissue had increased to 95%, slough was reduced to 5% and the wound edges had become flushed with the wound bed [Figure 2]. Exudate levels remained moderate, but dressing wear time was stable.

By day 32, the wound had reduced in size to 5.1cm (L) x 2.4cm (W) x 0.5cm (D), with 100% granulation tissue and low exudate. Wound edges remained flush and periwound erythema had resolved [Figure 3].

Conclusion

This case demonstrates the healing of a complex, previously non-healing abscess using blue light therapy combined with ConvaMax™ Superabsorber Dressing.



Figure 1. Initial wound presentation. Abscess located on the upper back with 85% granulation and 15% slough.



Figure 2. Progress at day 18: Granulation tissue increased to 95%, slough reduced to 5%. Wound edges appear flush with the wound bed.



Figure 3. Wound status at day 32: Wound reduced in size with 100% granulation and low exudate. Periwound erythema markedly reduced.

The dressing was selected over foam due to the need for a highly absorptive secondary dressing. Within 32 days, the wound showed complete granulation, reduced dimensions and improved skin condition.

CASE 3: Management of a surgical wound post-laminectomy

Author details: **Dr Soo-Bin Lee**, Orthopaedic Surgeon, Catholic Kwandong University International St Mary's Hospital, South Korea

Clinical presentation

- A 71-year-old female presented with acute neck pain and radiating pain to the right upper extremity following minor trauma. MRI confirmed a burst fracture of the T1 vertebra with associated spinal cord and nerve root compression
- The patient underwent posterior decompression and fusion at levels C7-T1-T2. Intraoperatively, a dural tear occurred during the laminectomy, which was repaired with sutures and sealed using a dural sealant. The surgical wound was closed in layers, with sutures used for the subcutaneous tissue and skin closure achieved with surgical staples [Figure 1]
- **Medical history:** Haemolytic anaemia and splenomegaly.

Wound presentation

- **Wound size:** 10cm (L)
- The wound was visibly leaking clear fluid, clinically suspected to be cerebrospinal fluid (CSF).

Treatment objectives: To manage CSF leakage, protect the wound from infection and support rapid healing while minimising patient discomfort and pressure-related complications.

Clinical outcomes

On day 1, the surgical wound was cleansed with saline and dressed with Aquacel® Foam Dressing and gauze to absorb the suspected CSF leakage [Figure 2]. Concurrently, the patient was administered intravenous antibiotics daily to reduce the risk of surgical site infection and potential meningitis due to the intraoperative dural tear.

By day 5, the wound demonstrated significant clinical improvement. The leakage had ceased and there were no signs of infection or inflammation. The dressing remained intact between changes, and no periwound maceration was noted.

By day 14, complete wound healing was achieved. The surgical site was dry, intact and free from signs of infection or inflammation. The patient tolerated treatment well and reported no further discomfort at the wound site.

Conclusion

This patient presented with a spinal surgical wound complicated by suspected CSF leakage following posterior



Figure 1. Post-surgical wound to the upper spine (C7-T1-T2 region) following laminectomy, posterior decompression and fusion.



Figure 2. Dressing appearance following daily change, showing suspected CSF leakage and traces of blood.

decompression and fusion at C7-T1-T2.

Daily wound management using Aquacel® Foam and gauze provided effective exudate control and supported tissue healing. Leakage resolved by day 5, with complete epithelialisation achieved by day 14 without complication.

The clinician highlighted that despite the patient's elevated risk of pressure damage due to prolonged supine positioning post-surgery, Aquacel® Foam offered good protection. The dressing was reported to be easy to apply and remove, maintaining skin integrity and controlling exudate effectively, ultimately contributing to improved clinical outcomes and high patient satisfaction.

CASE 4: Management of a stage 4 trochanteric pressure ulcer

Author details: **Professor Yong MinChae**, Sahmyook Seoul Hospital, South Korea

Clinical presentation

- A 75-year-old female, bedbound due to reduced mobility, presented with a stage 4 pressure ulcer to the left trochanter. The ulcer was initially unstageable and required surgical debridement
- **Medical history:** Dementia.

Wound presentation

- **Wound size:** 1cm (L) x 1cm (W) x 0.2cm (D); low levels of exudate
- **Wound edges:** Erythema extending up to 5cm.

Treatment objectives: To control infection risk and promote a moist healing environment to support re-epithelialisation.

Clinical outcomes

Initial treatment involved the use of medical-grade honey, hydrophobic antimicrobial ribbon gauze and a silicone foam dressing. Despite regular debridement and dressing changes, there was no significant improvement in the wound bed by day 21. However, the erythema had reduced slightly, measuring 3cm from the wound edge.

Given the lack of wound progression, the care plan was revised. Aquacel® Foam Pro was introduced as the primary dressing and applied daily [Figure 1]. After 14 days, the wound bed appeared dry [Figure 2]. To maintain a moist healing environment, medical-grade honey was reintroduced beneath the Aquacel® Foam Pro. Dressing frequency was initially maintained daily and later reduced to alternate days, based on exudate levels.

By day 30 of Aquacel® Foam Pro use, periwound erythema had further decreased to 1.8cm [Figure 3]. The patient was subsequently discharged and referred to community nursing services for continued wound care.

Conclusion

This case involved a patient with a stage 4 pressure ulcer to the left trochanter following prolonged immobility. Daily dressing changes were initially required due to the patient's need for frequent repositioning and high risk of further pressure injury; otherwise, the dressing could have remained in place for longer periods. Aquacel® Foam Pro adhered securely without causing skin irritation and was reported to be cost-effective by eliminating the need for additional secondary dressings. The dressing supported wound healing and granulation, and in this instance, the



Figure 1. Initial presentation of the left trochanter pressure ulcer on day 21, prior to the introduction of Aquacel® Foam Pro. Wound bed shows limited progress despite regular dressing changes.



Figure 2. Wound bed 14 days after Aquacel® Foam Pro application, appearing dry. Medical-grade honey was introduced at this stage.



Figure 3. Wound status on day 30 of Aquacel® Foam Pro use, showing reduced erythema (1.8cm from wound edge) and evidence of healing, prior to discharge for community care.

addition of medical-grade honey helped maintain an optimal moist environment in a low-exudate wound.

CASE 5: Management of a complex sacral pressure injury

Author details: **Dr Nyana Kalaiwani Krishnan, Dr Sharifah Nur Umaymah Wafa, SN Afifah Azman**, Wound Care Unit, Hospital Shah Alam, Malaysia

Clinical presentation

- A 36-year-old male developed a sacral pressure injury during a prolonged ICU stay for severe COVID-19, during which he was intubated and immobile. The wound resulted from difficulties in offloading pressure, attributed to the patient's high BMI
- Surgical debridement was performed and initial treatment involved povidone-soaked dressings with limited success as the patient experienced difficulty keeping the dressings dry due to stool passage
- **Medical history:** Hypertension, class 2 obesity.

Wound presentation

- **Wound size:** 15cm (L) x 10cm (W) x 7cm (D); with deep tracking and lateral undermining
- **Tissue composition:** 80% granulation tissue, 20% slough (in undermined areas); high serous discharge
- **Wound edges:** Moderate maceration
- **Additional** MSSA infection confirmed; antibiotic therapy completed during admission.

Treatment objectives: To control exudate and support healthy granulation, particularly within the undermined wound areas.

Clinical outcomes

Treatment began with Aquacel® Extra™Hydrofiber® dressings, silver spray and topical antimicrobial cream. Despite the presence of high levels of exudate and biofilm, early granulation tissue was preserved [Figure 1]. Dressings were changed every 3 days with family support at home and weekly in clinic.

By day 29 [Figure 2], exudate levels had reduced to moderate, and the wound showed clear signs of epithelial advancement. Aquacel® Extra™ continued to be used to pack the undermined areas, promoting granulation from within and maintaining moisture balance without encouraging hypergranulation.

From day 36, Aquacel® Foam was introduced as a secondary dressing to maintain moisture and improve patient comfort. Exudate decreased to minimal levels, with clear epithelial progression and advancing wound edges.

By day 78 [Figure 3], the wound was approximately 95% closed, dry and free from infection or inflammation. The patient was discharged with no maceration or recurrence.



Figure 1. Initial presentation of the sacral pressure injury measuring 15cm x 10cm x 7cm with deep tracking and lateral undermining.



Figure 2. Day 29: The wound had significantly reduced in size, visible tissue and healthy granulation, reduced levels of exudate.



Figure 3. Day 78: Approximately 95% closure, dry wound bed, no signs of infection or maceration and healthy epithelial tissue.

Conclusion

After 58 days, the combined use of Aquacel® Extra™ Hydrofiber® and Aquacel® Foam, with silver spray and antimicrobial cream, significantly improved the infected sacral pressure injury. Aquacel® Extra™ managed infection and exudate, while Aquacel® Foam maintained a moist environment and enhanced patient comfort. Both dressings were easy to apply and remove, and the patient was able to mobilise confidently without discomfort or irritation.

CASE 6: Management of multiple traumatic skin tears

Author details: **Dr Yi-Hsien Chen**, Director of Section of Resuscitation Science, Department of Emergency Medicine, Chia-Li Chi Mei Hospital, Tainan, Taiwan

Clinical presentation

- A 90-year-old male presented with bilateral skin tears to the lower legs, including one large skin tear on the left leg [Figure 1a] and multiple smaller tears on the right leg [Figure 1b] around the popliteal fossa, with visible blood clots following a fall from a tree
- **Medical history:** No known medical history.

Treatment objectives: To control bleeding, preserve viable skin flaps, prevent infection and promote optimal wound healing with minimal dressing disruption.

Clinical outcomes

On day 1, blood clots were gently removed using normal saline solution and the skin flaps were repositioned and secured with wound closure strips [Figure 2a and 2b]. Aquacel® Ag+ Extra™ Dressing was applied to manage potential bioburden, followed by Aquacel® Foam Dressing to provide secondary protection [Figure 2c and 2d].

By day 3, the patient was reviewed in an outpatient clinic. The skin flaps had successfully reattached to the surrounding tissue, with no signs of infection or exudate [Figure 3a and 3b].

Conclusion

This case involved the successful management of traumatic bilateral skin tears in an elderly patient using a combination of wound closure strips and advanced wound care dressings. The use of Aquacel® Ag+ Extra™ Dressing, with its antimicrobial properties, alongside Aquacel® Foam Dressing, facilitated an optimal moist healing environment while offering exudate management and protection from further trauma.

Within 4 days, the skin flaps had adhered well and healing progression was evident. The clinician highlighted the effectiveness of Aquacel® Foam Dressing in providing cushioning, maintaining moisture balance and preventing maceration. The patient's family expressed satisfaction with the treatment noting the convenience and reduced frequency of dressing changes.



Figure 1. Bilateral traumatic skin tears to left (a) and (b) right leg.

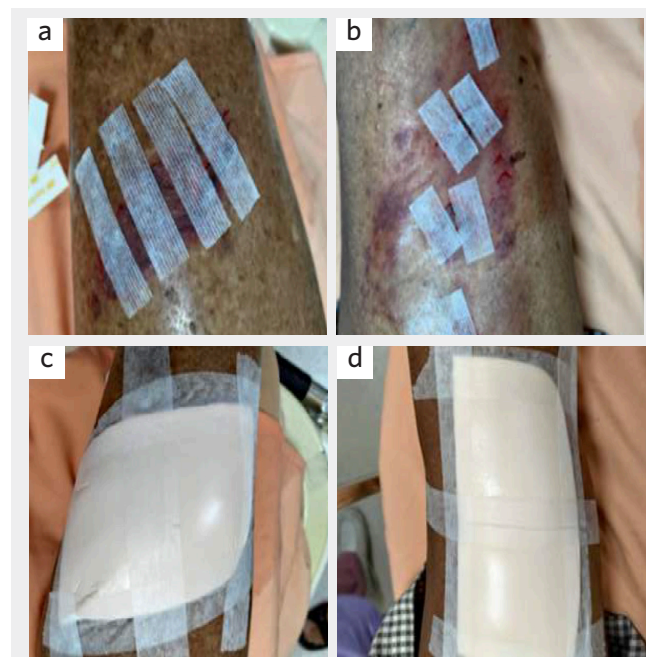


Figure 2. Day 1: Skin flaps repositioned and secured with wound closure strips to (a) left and (b) right leg; Aquacel® Ag+ Extra™ and Aquacel® Foam Dressings applied to (c) left and (d) right leg.

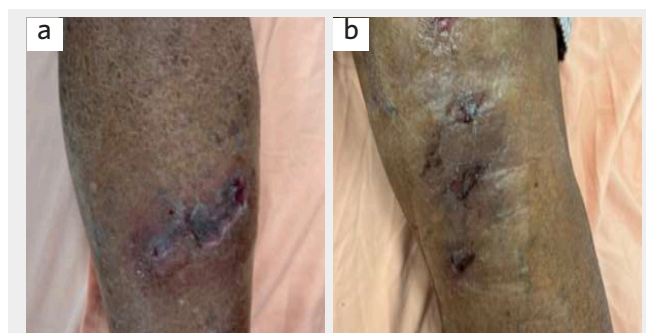


Figure 3. Day 3 outpatient review: Skin flaps on (a) left and (b) right leg appear healthy with no exudate or signs of infection.

CASE 7: Management of a large forearm skin tear

Author details: **Dr Chao-Sheng Chang**, Director, Emergency and Rescue Section, Department of Emergency Medicine, E-Da Hospital, Kaohsiung, Taiwan

Clinical presentation

- An 81-year-old male presented to the emergency department with pneumonia and impending respiratory failure. During assessment, a large skin tear was noted on his left forearm
- The incomplete skin flap was covered with a neomycin gauze and an elastic bandage which had been in situ for 3 days prior to presentation [Figure 1].

Treatment objectives: To preserve viable tissue, prevent infection and promote rapid healing of the skin tear.

Clinical outcomes

On day 1, the skin tear was irrigated with saline to separate the skin flap from the surrounding tissue [Figure 2a]. The skin flap was then gently repositioned [Figure 2b] and a blood clot was removed from between the epidermis and dermis. Pressure was applied to control bleeding. The wound was patted dry and the flap was secured using tissue adhesive. Aquacel® Ag+ Foam Dressing was applied to the site [Figure 3a].

At follow-up on day 6, the skin flap had successfully reattached with no signs of infection [Figure 3b]. The patient's pain had significantly decreased.

Conclusion

This case involved a large skin tear to the left forearm in an elderly patient which was managed by cleansing, realignment of the skin flap and application of tissue glue and Aquacel® Ag+ Foam Dressing.

Within 6 days, the wound showed no signs of infection.

This case demonstrates the effectiveness of Aquacel® Ag+ Foam Dressing in supporting skin flap adherence, preventing infection and maintaining a moist wound environment to optimise healing while protecting the periwound area.



Figure 1. Initial presentation of the large skin tear on the left forearm.



Figure 2. Skin tear (a) following irrigation with saline to separate skin flap from surrounding tissue and (b) repositioning.



Figure 3. Day 6: Skin tear appearance (a) prior to and (b) following removal of Aquacel® Ag+ Foam Dressing.

CASE 8: Management of a postoperative laparotomy wound

Author details: **Dr Nyana Kalaiwani Krishnan, Dr Sharifah Nur Umaymah Wafa, SN Afifah Azman**, Wound Care Unit, Hospital Shah Alam, Malaysia

Clinical presentation

- A 30-year-old female diagnosed with a left ovarian tumour underwent laparotomy, left salpingo-oophorectomy, omentectomy and peritoneal cytology
- The procedure was complicated by wound breakdown with a rectus defect, occurring 11 days postoperatively [Figure 1].

Wound presentation

- **Location:** Midline abdomen, below the umbilicus
- **Wound size:** 9cm (L) x 6cm (W) x 2cm (D)
- **Tissue composition:** Minimally sloughy wound bed with high volume of exudate and serous discharge; suspected biofilm.

Treatment objectives: To manage exudate, reduce suspected biofilm and prepare the wound for potential re-suturing.

Clinical outcomes

A treatment plan was initiated using Aquacel® Ag+ Extra™ Hydrofiber® as the primary dressing and Aquacel® Foam as the secondary dressing. The patient was reviewed weekly in clinic [day 7; Figure 2] and independently changed the secondary dressing every 4 days at home.

By day 19, the wound bed appeared clean. Biofilm and exudate decreased, allowing for step-down to Aquacel® Foam alone.

By day 25 [Figure 3], there was minimal exudate and clean, advancing wound edges.

By day 39 [Figure 4], with no biofilm or exudate present, the dressing was changed to an absorbent dressing alone. The wound was almost closed at this point and the patient was discharged on day 45 following confirmed healing.

Conclusion

This case involved a postoperative abdominal wound complicated by wound breakdown and high levels of exudate. Initial treatment with Aquacel® Ag+ Extra™ and Aquacel® Foam dressings effectively reduced biofilm and managed exudate. Over time, the wound improved significantly, allowing step-down to simpler dressings and avoiding the need for re-suturing. The dressings were well tolerated, easy for the patient to apply independently and contributed to positive healing outcomes while reducing patient anxiety.



Figure 1. Initial presentation of midline abdominal wound with high exudate level with suspected biofilm present. Dressings used: Aquacel® Ag+ Extra™ Hydrofiber® and Aquacel® Foam.



Figure 2. Day 7: Dressings used: Aquacel® Ag+ Extra™ Hydrofiber® and Aquacel® Foam.



Figure 3. Day 25: Clean wound bed with minimal exudate and advancing wound edges. Dressings used: Aquacel® Foam.



Figure 4. Day 39: Clean wound bed with no biofilm detected and no exudate. The wound edges are advancing and the wound is almost closed.

CASE 9: Management of paediatric scald burns

Author details: **Coreen Low**, Senior Nurse Manager, Plastic, Reconstructive and Aesthetic Surgery, KK Women's and Children's Hospital, Singapore

Clinical presentation

- A 2-year-old girl sustained a scald injury after accidentally coming into contact with a pail of boiling water. Her parents initially applied ice before taking her to hospital, where the burns were irrigated with cool water for 20 minutes.

Wound presentation

- **Location:** Right buttock and posterior thigh
- **Wound size:** 16cm (L) x 8cm (W)
- **Extent:** 6% TBSA (total body surface area) with superficial partial-thickness burns; 1% TBSA superficial burn to the right calf
- **Tissue composition:** Weepy, denuded surface with blanching; high levels of thin, watery, colourless fluid from ruptured blisters
- **Wound edges:** Healthy and intact.

Treatment objectives: To prevent infection, reduce risk of scarring and promote healing.

Clinical outcomes

On day 1, the wound underwent gentle cleansing ("scrub down"; **Figure 1**) and was dressed with a polyurethane absorbent foam dressing, gauze and a crepe bandage.

By day 2 [**Figure 2a**], due to high volumes of fluid, the dressing was changed to ConvaMax™ Superabsorber and secured with adhesive soft roll tape and a crepe bandage [**Figure 2b**]. To protect the perineal area from contamination with urine or faeces, a transparent film dressing was applied. The patient was prescribed analgesia before dressing changes every 3–4 days.

At the second dressing change (day 6), the dressing remained intact and was removed using an adhesive remover. Approximately 70% epithelialisation was observed, with minor oozing at the proximal wound edge. Aquacel® Ag Burn was applied to manage exudate and support continued healing [**Figure 3**].

By day 10, the wound had fully epithelialised. The skin appeared dry and scaly [**Figure 4**]. A follow-up appointment was scheduled for review in 4 weeks.

Conclusion

Timely intervention with appropriate dressing selection



Figure 1. Initial wound presentation on day 1 following cleansing.

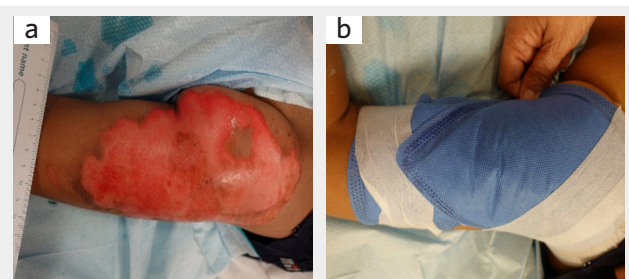


Figure 2. Day 2 (a) high fluid levels and (b) superabsorbent dressing secured with adhesive soft roll tape and crepe bandage; transparent film dressing applied near the perineum for protection.

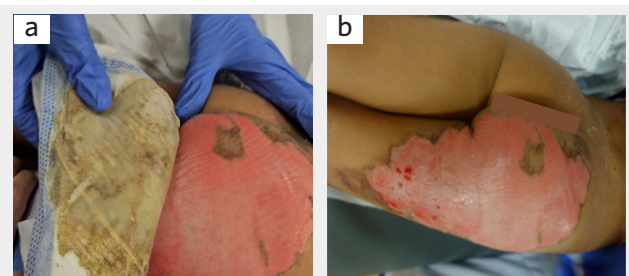


Figure 3. Dressing (a) during and (b) post removal on day 6 showing epithelialisation of the wound bed with minimal oozing at proximal end.



Figure 4. Day 10: The wound was fully epithelialised with dry, scaly skin. Follow-up scheduled in 4 weeks.

supported effective exudate management and healing. The wound closed within 10 days with no signs of infection, and aftercare focussed on skin conditioning and scar prevention.

CASE 10: Management of a burn wound induced by moxibustion

Author details: **Ma Xiaoni**, Certified Wound Care Nurse, Department of Burns and Plastic Surgery, Shaanxi Provincial People's Hospital, Mainland China

Clinical presentation

- A 64-year-old male presented with blistering to the right calf due to scalding following moxibustion [Figure 1a]. The blister remained unhealed for 20 days
- **Medical history:** Diabetes.

Wound presentation

- **Wound size:** 3cm (L) x 2.5cm (W)
- **Tissue composition:** Scalding; 100% yellow slough; residue of traditional Chinese medicine present
- **Wound edge:** Macerated, red, oedematous and warm.

Treatment objectives: To remove necrotic tissue, reduce exudate, and manage pain and anxiety relating to scarring.

Clinical outcomes

On day 1, the wound was cleansed with sodium chloride and conservatively debrided using a sharp technique [Figure 1b]. Zinc sulphadiazine ointment and gauze were applied, followed by Aquacel® Foam [10cm x 10cm] selected for its superior absorptive capacity. The dressing supports a moist wound environment and acts as a barrier against bacterial infiltration and external contamination, while ensuring secure fixation. Dressing changes were scheduled every other day to manage exudate levels.

By day 6, the wound had reduced in size to 2.7cm (L) x 2.2cm (W) with 100% red granulation tissue in the wound bed and reduced exudate levels. Short-wave ultraviolet radiation was administered and recombinant bovine alkaline fibroblast growth factor gel was applied to the wound, followed by Aquacel® Foam.

By day 18, the wound size had reduced to 1.5cm (L) x 1.1cm (W). Exudate levels were low and the wound edge appeared normal, with hyperpigmentation present in the peripheral skin [Figure 2]. Pain levels had decreased from moderate to mild.

By day 28, wound closure was achieved [Figure 3].

Conclusion

The patient presented with a blister on the right calf, resulting from moxibustion performed 20 days prior. Moxibustion is a traditional Chinese medicine therapy involving the burning of mugwort near the skin to stimulate acupuncture points. In this case, it resulted in scalding.

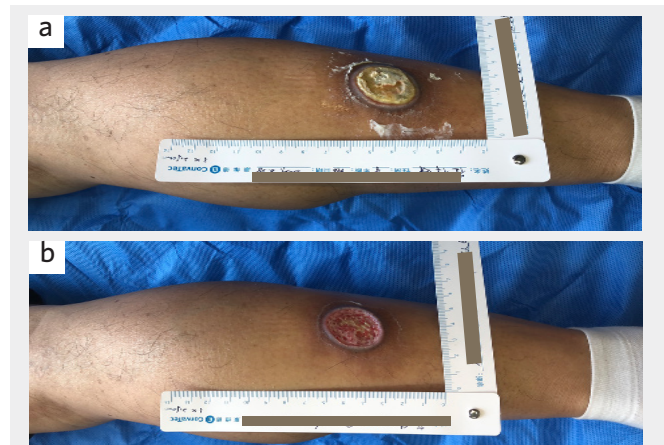


Figure 1. Wound on day 1: (a) Pre- and (b) post-cleansing and debridement with zinc sulphadiazine ointment and gauze applied, followed by Aquacel® Foam.

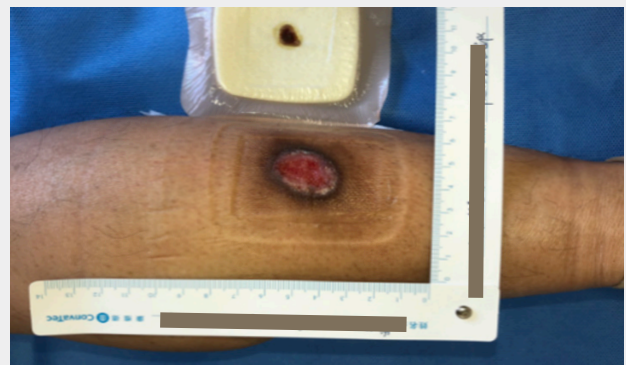


Figure 2. Wound on day 18: 100% granulation tissue, minimal exudate and reduced wound size.

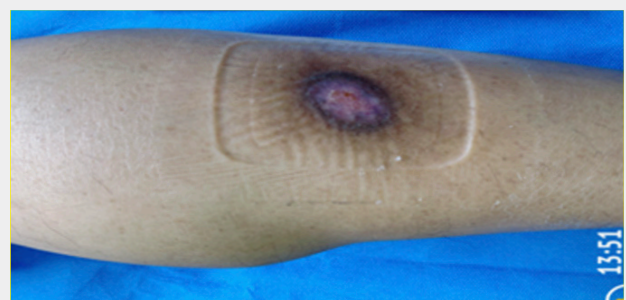


Figure 3. Wound on day 28: Complete wound closure achieved.

The wound was managed with Aquacel® Foam, with dressings changed every 2 days. Ultraviolet radiation and recombinant bovine alkaline fibroblast growth factor gel were also applied to support healing. Positive outcomes were achieved within 28 days, with progressive improvement and wound size reduction at each follow-up.

